How to File Your Claim:

1. You complete Part A
2. Have your Physician or Optometrist complete Part B
3. Have the Supplier complete Part C
4. Attach copy of itemized statement
5. Send the completed form to OPTIX Vision Plan

CLAIM FOR VISION CARE BENEFITS

INDEMNITY PLAN

Miami-Dade County Public Health Trust

Mail completed form to:

VISION CARE, INC.
OPTIX Vision Plan
P.O. Box 30349
Tampa, FL 33630-3349
1-800-393-2873
8am-4:45pm, Monday-Friday

PART A — PATIENT & INSURED INFORMATION — Claim Number

1. PATIENT'S NAME (First, Middle, Last name)	2. PATIENT'S BIRTHDATE (Month / Date / Year)	3. EMPLOYEE'S NAME (First, Middle, Last name) ❑ Active ❑ Retired
4. EMPLOYEE'S ADDRESS (Street, City, ST, Zip)		6. EMPLOYEE SOCIAL SECURITY NUMBER
7. IF PATIENT CHILD IS OVER 19, ARE THEY A PART-TIME OR FULL-TIME STUDENT? ❑ YES ❑ NO	8. PATIENT'S SEX ❑ MALE ❑ FEMALE	9. PATIENT RELATIONSHIP TO INSURED ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER
10. OTHER VISION COVERAGE- ENTER NAME OF POLICYHOLDER PLAN (NAME,ADDRESS AND POLICY OR OPTICAL ACCT NO.)	11. WAS CONDITION RELATED TO AN ACCIDENT? ❑ YES ❑ NO	12. ARE ANY VISION SERVICES PROVIDED BY A HEALTH MAINTENANCE ORGANIZATION? ❑ YES ❑ NO (LIST SERVICES)

13. DOES YOU SPOUSE WORK? ❑ YES ❑ NO
IF YES, WHAT IS THEIR EMPLOYER'S NAME?

I hereby authorize the provider of vision care service and/or supplies to release any information request with respect to this claim and the attached bills. I certify that the information furnished by me in support of this claim is true and correct.

SIGNED (Employee)_____
also
DEPENDENT (if patient and not a minor)_____

DATE_____

PART B — EXAMINING PHYSICIAN

1. DIAGNOSIS:_____
2. DATE OF SERVICE_____ EXAM? ❑ YES ❑ NO CONTACT LENS EXAM? ❑ YES ❑ NO
3. DOES PATIENT REQUIRE A PRESCRIPTION CHANGE AT THIS TIME? ❑ YES ❑ NO DO FRAMES NEED CHANGING? ❑ YES ❑ NO
   AXIS CHANGE _____ DEGREE DIOPTER. SPHERE OR CYLINDER CHANGE _____
   WILL LENSES IMPROVE VISUAL ACUITY BY AT LEAST ONE LINE ON A STANDARD CHART? ❑ YES ❑ NO
4. ARE ANY OF THESE CHARGES COVERED BY ANY OTHER INSURANCE, GOVERNMENT OR WORKER'S COMP? ❑ YES ❑ NO
   IF YES, PLEASE GIVE NAME OF OTHER INSURANCE COMPANY AND NAME OF GROUP_____
5. CHARGE FOR THIS EXAMINATION $_____ AMOUNT PAID BY EMPLOYEE $_____

I HEREBY CERTIFY THAT THE ABOVE STATEMENT ACCURATELY DESCRIBES THE SERVICES RENDERED AND THAT I AM A/AN _____(type of physician) LICENSED TO PRACTICE BY THE STATE OF_____.

MUST BE FURNISHED UNDER AUTHORITY OF LAW

SOCIAL SECURITY NUMBER EMPLOYER I.D. NUMBER
PHYSICIAN'S NAME DATE SIGNATURE
ADDRESS PHONE ( )

PART C — SUPPLIER STATEMENT

THE FOLLOWING LENSES AND/OR FRAMES WERE ORDERED ON _____ FOR THE ABOVE PATIENT AS PRESCRIBED ON _____ BY MYSELF OR BY DR. _____.

MATERIALS SUPPLIED TYPE OF LENS	❑ PLASTIC NO. OF LENS	❑ GLASS CHARGE
❑ SINGLE VISION	_____	$_____
❑ BIFOCAL	_____	_____
❑ TRIFOCAL	_____	_____
❑ CONTACT ❑ HARD ❑ SOFT ❑ DISPOSABLE	_____	_____
❑ TINT NO.	_____	_____
❑ OTHER	_____	_____
TOTAL LENS CHARGE		$_____
TOTAL FRAME CHARGE		$_____
TOTAL CHARGE		$_____

IS THERE ANY OTHER INSURANCE WHICH COVERS THESE CHARGES? ❑ YES ❑ NO

IF YES, PLEASE GIVE NAME OF INSURANCE COMPANY AND GROUP:
_____
AMOUNT PAID BY EMPLOYEE: $ _____
SS NO._____EMPLOYER I.D. NO._____

NAME OF SUPPLIER_____
ADDRESS_____
SIGNATURE_____ TITLE _____ DATE _____ PHONE _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACTS, MATERIALS THERETO, IS GUILTY OF INSURANCE FRAUD WHICH IS A CRIME.

VISION CARE BENEFITS ARE PAYABLE ONLY TO THE PATIENT AND NOT ASSIGNABLE.